

NJ Department of Human Services

**FREQUENTLY ASKED QUESTIONS (FAQs) FOR PROVIDERS
NJ FamilyCare MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS)**

Assisted Living Billing Process when Member is Pending Enrollment in NJ FamilyCare	2
Clinical Eligibility Determination	3
Eligibility for MLTSS	4
Enhanced At Risk Criteria Pre-Admission Screening (EARC PAS) Authorization	5
FFS Member Transition to MLTSS for Custodial FFS Members	8
Financial Eligibility Determination	9
MCO Provider Network and MLTSS	9
MCO Contract Parameters on Benefits Coordination with other Insurers	11
MCO Contract Parameters for MLTSS Providers	12
MCO Contract Parameters for Residential Providers	15
MLTSS Member Eligibility Confirmation	17
MLTSS Member Enrollment and Eligibility Information	18
MLTSS Patient Pay Liability/Cost Share	20
Nursing Facility Resident Discharge	22
Operations	24
Resources for NJ FamilyCare MLTSS Providers	26
Transition from Fee for Service Approval to Managed Care	26

ASSISTED LIVING BILLING PROCESS WHEN MEMBER IS PENDING ENROLLMENT IN NJ FAMILYCARE

1. What qualifies an AL program to submit claims to request Fee for Service (FFS) reimbursements for its AL services provided to a resident?

- AL programs need to submit a request for FFS reimbursement for AL services provided the resident's clinical and financial eligibility have been determined and the individual is receiving AL services, but his/her enrollment in a MCO is pending.

2. What does an AL program need to provide to the state to receive FFS reimbursements for the AL services provided to a resident?

- AL providers with NJ FamilyCare-eligible residents "clinically" eligible for AL services, but pending MCO enrollment must request assignment of an Assisted Living Special Program Code (SPC) in order for the provider to be paid FFS.
- The provider must submit the following to the DMAHS Office of Provider Relations at mahs.provider-inquiries@dhs.state.nj.us. They must provide the following information:
 - Resident' name
 - Date of birth
 - Medicaid ID number
 - Date member met financial eligibility (Institutional Medicaid)
 - Date the member became "clinically" eligible for AL services (PAS Approval Date)
 - Facility name
- If the member meets the criteria, the AL SPC will be added and the provider will bill FFS for the time frame specified.

3. How much time does the AL provider need to allow before submitting claims?

- The AL provider must allow 20 business days for assignment of SPC 62 which allows for provider to be paid for FFS for AL services. The provider will receive a response via e-mail regarding the individual members who are assigned a SPC 62.

For additional information refer to the Medicaid Newsletter listed below:

- <https://www.njmmis.com/downloadDocuments/24-14.pdf>
 - Volume 24: Number 14: Fee for Service (FFS) Coverage of Assisted Living Programs and Managed Long Term Services and Supports(MLTSS)

CLINICAL ELIGIBILITY DETERMINATION

- 1. Will the hospitals still be doing the Enhanced At-Risk Criteria Screening – (EARC-PAS) for hospitalized patients going to the nursing facility (NF) on NJ FamilyCare?**
 - Yes. The EARC PAS (LTC-34) is a screening tool which provides 90-day authorization for acute care hospital patients being discharged to a Medicaid certified nursing facility (NF) in the NJ FamilyCare program without Managed Care Organization (MCO) enrollment.
 - The NF authorization process will be the responsibility of the NJ FamilyCare MCOs under MLTSS. The EARC tool will only be utilized for non-Medicaid participants and will serve as a 90-day temporary authorization.
- 2. Who and what will determine where a MLTSS member is going to be placed in the continuum of care?**
 - The NJ FamilyCare MCOs will have the acute and primary health care services and home and community-based services coordinated (care managed) for their members by a MLTSS care manager. The choice of services and setting is based on consumer preference and care needs.
- 3. If NJ FamilyCare will be converting the long-term care facility payments to the NJ FamilyCare MCOs, how will the care management take place?**
 - All MLTSS beneficiaries will have a care manager assigned to them by the MCO. The care manager will visit with NJ FamilyCare residents in long-term care facilities
 - Evaluate the resident's service and care coordination needs on an annual basis and as the care needs change;
 - Help the resident to develop a plan of Care (POC);
 - Help the resident to select and arrange his/her services;
 - Work with the resident and his/her doctors to ensure that all needed medical and dental visits and screenings take place;
 - Assist with service problems or concerns, and
 - Assist with the managed care plan's participant rights.
- 4. How will the NJ FamilyCare MCO cover community services like cognitive rehabilitation and residential long-term care for patients discharged from post-acute facilities?**
 - The NJ FamilyCare MCO contract parameters outline the continuity of care requirements for members who will be transitioning to MLTSS. The MCO care manager will evaluate service needs of all members and provide care coordination needs on an annual basis and as the care needs change.

- **What criteria does a member enrolled in NJ FamilyCare MCO need to meet in order to receive MLTSS?**
- Providers and/or NJ FamilyCare members must contact the MCO for a clinical assessment. In addition, the CWA must be contacted regarding the financial eligibility requirements. A member must meet the following criteria to receive MLTSS services:
 - Clinical: person meets the qualifications for nursing home level of care, which means that the person requires assistance with a minimum of three activities of daily living (ADL) such as bathing, toileting and mobility. The MCO will complete the NJ Choice assessment and forward it to the Division of Aging Services (DoAS)/Office of Community Choice Options (OCCO) for review and approval.
 - Institutional Medicaid Eligibility: Financial Eligibility for MLTSS includes a higher income and five-year “look back” of assets. The County Welfare Agency (CWA) completes the financial determination.
- **What entity will handle the Pre-Admission Screening Process for new members to NJ FamilyCare MLTSS?**
- DoAS/OCCO will conduct the Pre-Admission Screening (PAS) process for individuals, who are new to NJ FamilyCare, and seeking clinical eligibility for MLTSS. The MCO will conduct the PAS for its members seeking clinical eligibility, which will then be reviewed and authorized by OCCO. All MLTSS members, regardless of their living arrangements, will receive annual re-evaluations by their MCO. The re-evaluations will be reviewed and authorized by OCCO.

ELIGIBILITY for MLTSS

1. What criteria must an individual meet to be eligible for MLTSS?

- To be eligible for MLTSS an individual must meet the following eligibility criteria:
 1. Categorical Eligibility
 - Aged – 65 years old or older, or
 - Blind **or** Disabled – Under 65 years of age and determined blind or disabled by the Social Security Administration or the State of New Jersey.
 2. Clinical Eligibility
 - A person meets the qualifications for nursing home level of care, which means that s/he requires limited assistance with a minimum of 3 activities of daily living (ADL) such as bathing, toileting and mobility or the consumer has cognitive deficits and ADL needs of supervision in greater than 3 ADL areas.
 3. Financial Eligibility –Institutional Medicaid
 - Income¹
 - Income for one person can be equal to or less than \$2,199* per month (2015).
 - All income is based on the gross amount.
 - Resources

- Resources must be at or below \$2,000 for an individual
 - In addition, the financial eligibility component includes a five-year “look back” at resources to insure that there were no assets transferred for less than fair market value in order to meet the requirements for Institutional Medicaid. Individuals in the Alternate Benefit Plan (ABP) should avail themselves of all income sources that they may be eligible to receive.
 - *Subject to annual change
- ¹Note that for children applying for MLTSS and who meet the nursing home level of care, parental income and resources are not counted in determining financial eligibility.

ENHANCED AT RISK CRITERIA PRE-ADMISSION SCREENING (EARC PAS) AUTHORIZATION

1. What is the EARC PAS?

- The EARC PAS (LTC-34) is a screening tool which provides a 90-day authorization for acute care hospital patients being discharged to a Medicaid certified nursing facility (NF) in the NJ FamilyCare program without enrollment in a Managed Care Organization (MCO). The Division of Aging Services, Office of Community Choice Options (DoAS/OCCO) is responsible for the authorization process. Hospital staff trained and certified through the DoAS-established curriculum can complete this tool.
- The authorized EARC PAS and all PASRR documents can be found at www.state.nj.us/humanservices/doas/home/forms.html and must accompany the patient to the NF to be permanently filed in his/her active NF chart. The NF will not be eligible for NJ FamilyCare reimbursement unless all required paperwork and processes have been completed and Medicaid financial eligibility has been approved.

2. Who should request the EARC PAS?

- The EARC is only completed in an acute care hospital setting. The hospital is responsible for completing the EARC and submitting it to DoAS/OCCO for review and authorization to the admitting NF.

3. What is the EARC target population?

- The target population is for individuals who are currently in an acute non-psychiatric hospital setting and are seeking admission to a NJ FamilyCare-certified NF or Special Care Nursing Facility (SCNF) ventilator unit. The facility expects to bill NJ FamilyCare for all or part of the stay because the individual is eligible for NJ FamilyCare but not yet enrolled in a MCO or potentially eligible for NJ FamilyCare within 180 days of NF admission.

4. Do members in NJ FamilyCare need an EARC PAS?

- Individuals enrolled in NJ FamilyCare are enrolled into an MCO. There may be a temporary period of Medicaid fee-for-service (FFS) coverage until the MCO enrollment occurs. Individuals who are enrolled in an MCO are required to obtain authorization from their MCO to enter a sub-acute rehabilitation facility, NF or SCNF.

5. Is an EARC necessary if the resident is pending for NJ FamilyCare or is not enrolled in an MCO?

- Yes. The EARC is for those individuals who are pending NJ FamilyCare eligibility or those with no enrollment yet in an MCO. Those individuals enrolled in an MCO need to follow the processes required under their MCO.

6. What is the difference between an authorization and PAS (Pre-Admission Screening)?

- An authorization is an MCO process to approve services for a period of time including in a NF.
- Pre-Admission Screening (PAS) is an assessment conducted by DoAS/OCCO to determine NF level of care clinical eligibility for individuals not enrolled in an MCO.
- Assessments to determine eligibility for MLTSS are conducted by both DoAS/OCCO and the MCO using the NJ Choice assessment tool. If the MCO conducts a NJ Choice assessment for MLTSS, it is submitted to and reviewed by DoAS/OCCO to determine MLTSS eligibility.
- An individual enrolled in an MCO is eligible for NF benefits with MCO authorization without being assessed for MLTSS. It is the provider's responsibility to contact the MCO to determine the authorization process.

7. If a resident is being admitted to a NF from the hospital and already on MLTSS, does the hospital need to get authorization and a PAS?

- An individual enrolled in MLTSS requires an authorization from the MCO.

8. Is a new EARC required for readmission to a NF after a hospital stay?

- EARCs conducted after January 1, 2015 are valid for one NF stay only. Upon admission to a hospital, a new EARC is required.
- Medicaid eligible individuals with a valid EARC or PAS in a NF before July 1, 2014 are considered NF EXEMPT and not eligible for MCO enrollment unless they change placement setting or payer source. These individuals do not require an EARC or PAS if they are hospitalized and returning to the NF after the hospital stay.

9. What happens if the patient is admitted to the NF on Medicare A and has a NJ FamilyCare MCO? How is the co-insurance covered beginning on the 21st day?

- The hospital and NF are responsible for communicating with the specific MCO to determine the MCO's authorization process and what is required based on the length of stay.

10. What if the patient is admitted to the NF from the hospital?

- The NF is responsible for determining if the patient is enrolled in an MCO. If the individual is enrolled in an MCO, the MCO is required to do the PAS, providing authorization to the provider. If the individual is NJ FamilyCare (fee for service) or pending NJ FamilyCare eligibility, a referral to OCCO must be made to conduct the PAS.

11. For pediatric patients, is a positive Level I PASRR screen required to be sent to the Division of Developmental Disabilities (DDD)?

- Yes, any individual who has a positive Level I is required to have the PASRR Level II completed by the applicable agency. DDD is still the Level II authority for positive Level I DDD screens regardless of the individual's age.

12. Will DoAS/OCCO assess Special Care Nursing Facility (SCNF) eligibility on site in acute hospitals?

- Yes, if the individual meets the Pre-Admission Screening criteria and eligibility for the SCNF and the individual is not enrolled in an MCO, then DoAS/OCCO will conduct an on-site assessment. The exception is for ventilator SCNFs as they can be authorized through the EARC process. [Note: If the individual is enrolled in an MCO, the MCO is responsible for conducting the assessment and authorization for Behavioral SCNF. These individuals are not to be referred to OCCO.]

13. If Medicare is the primary payer and the MCO secondary for an individual entering a sub-acute rehabilitation (SAR) facility, is authorization by the MCO still required (assuming the patient has the full 100 Medicare SAR days remaining)?

- It is the provider's responsibility to outreach the MCO to determine the process for coordination of benefits to ensure coverage during the NF stay.

14. Is an EARC required for a pediatric patient going from an acute rehabilitation facility to a SCNF?

- The EARC is not conducted in an acute rehabilitation facility. Individuals seeking admission to a SCNF from a NF or SAR are subject to either the PAS (if there is no MCO enrollment) or assessment and authorization (MCO enrollees).

15. If a patient is admitted to a NF/SCNF/SAR with an authorization from an MCO but then the resident's Medicaid eligibility terminates, will the facility get paid if there is no EARC or PAS? Can the facility request a PAS from DoAS/OCCO?

- If the individual is terminated and is no longer eligible for NJ FamilyCare, then NJ FamilyCare would not be the payer source regardless of any authorization by the State or MCO.

16. If a resident is a positive level 1 and is only going to need short term rehabilitation services but will be in the NF for longer than 30 days, can the individual be admitted to the NF?

- Regardless of the length of stay when an individual is admitted to a NF, a PASRR Level I is required prior to admission. All positive Level 1 PASRR screens require a Level II determination prior to admission. If the 30 day exempted hospital discharge is used, then it is the responsibility of the NF to follow through and complete the level II prior to the 40th day from admission as per the federal regulations.

17. Can a patient be admitted into a Medicaid certified NF without an EARC?

- Individuals entering a Medicaid certified nursing facility require one of the following dependent upon their insurance coverage:
 - a) EARC
 - b) Pre-Admission Screening (PAS)
 - c) NJ FamilyCare MCO Authorization
- Individuals who do not expect to become Medicaid eligible during their stay in the nursing facility do not require an EARC or PAS. They may require authorization dependent on their insurance coverage.

18. What happens when the hospital says it will complete the EARC, but fails to do so and discharges the patient?

- The admitting provider is responsible for obtaining the proper EARC, PAS or MCO Authorization as well as the PASRR Level I and Level II, if applicable prior to admission. Providers should not be accepting individuals without these requirements. If a provider accepts an individual without the required documentation, it may jeopardize reimbursement.

FEE-FOR-SERVICE (FFS) MEMBER TRANSITION TO MLTSS for CUSTODIAL FFS MEMBERS

1. Explain the triggers, which would cause a Medicaid eligible individual with a valid EARC or PAS in a NF or a SCNF before July 1, 2014 (who is considered NF EXEMPT and not eligible for MCO enrollment) to move into MLTSS?

- The triggers are as follows:
 - a) A change in a resident's level of care, meaning the resident is transitioning from a NF to a SCNF; transitioning from a SCNF to a NF, or transitioning from a SCNF to a different kind of SCNF (i.e. behavioral to vent);
 - b) A change in a NF/SCNF provider, meaning a resident was admitted to the hospital from the NF and subsequently discharged and admitted to a different NF; or the resident was transitioned from one NF to a different NF;
 - c) New admission to MLTSS, meaning the individual is transitioning from the NF to the community and eligible for MLTSS; or is a new NF admission for NJ FamilyCare (NJ FAMILYCARE);
 - d) New individual to NJ FamilyCare (NJ FAMILYCARE) and eligible for MLTSS, meaning the individual is newly eligible for NJ FAMILYCARE and needs custodial care in a nursing home. (Note: A change from the Medically Needy program to NJ FAMILYCARE Care will trigger enrollment into MLTSS if individual meets clinical eligibility criteria.)
 - e) A change from rehabilitation to custodial care (regardless of when admission to the NF occurred), meaning that an individual's Medicare benefits are exhausted after July 1 and the individual is determined to need custodial care.

Note: If a member is custodial FFS prior to July 1, 2014 and uses the Medicare benefit for an acute or skilled service this is not a trigger for change in a members Medicaid enrollment.

FINANCIAL ELIGIBILITY DETERMINATION

1. Where do residents apply for New Jersey's Medicaid program, NJ FamilyCare?

- Individuals must apply for NJ FamilyCare at the County Welfare Agency (CWA). The submission of an application with its supporting documents is required to determine financial eligibility.

2. Who do residential providers contact to insure that the member meets financial eligibility for MLTSS if member is currently approved in NJ FamilyCare for "community Medicaid"?

- Institutional Medicaid eligibility is required for MLTSS. Providers and the MCO should contact the CWA regarding a member's eligibility for Institutional Medicaid. Institutional Medicaid requires a PAS and a five-year "look back" for transfer of assets for less than fair-market value.

3. Who do residential providers contact if an individual is admitted to a facility pending NJ FamilyCare eligibility?

- The CWA determines financial eligibility for NJ FamilyCare. If a residential provider has a release from the member, the provider can contact the CWA regarding a member's financial eligibility. If the provider does not have a release, the member and/or their representative should contact the CWA.

4. If the Provider has a question regarding member's eligibility who do they contact?

Providers can review a member's eligibility information in E_mevs. If they have specific questions regarding cost share and/or financial determination, they should contact the CWA where the member resides.

The link below provides listing of local CWAs.

<http://www.nj.gov/humanservices/dfd/programs/njsnap/cwa/index.html>

MCO PROVIDER NETWORK AND MLTSS

1. What is the health plan's responsibility with regard to establishing a provider network?

Each health plan has specific responsibilities when contracting with providers, including:

- a) offering an application when considering enrolling providers in network;
- b) credentialing/re-credentialing providers;
- c) establishing a contract with providers selected to be network providers and subcontractors;
- d) creating an annual provider manual and preparing updates as necessary;
- e) offering provider education and outreach;
- f) providing access to call center staff to resolve payment issues; and,
- g) providing a process for claim and utilization appeals.

2. How do health plan's contract with providers?

- The health plan will establish written agreements and/or contracts with providers selected to service enrolled members. Templates for provider contracts are reviewed and approved by the NJ Division of Medical Assistance and Health Services (DMAHS) and the NJ Department of Banking and Insurance (DOBI) before they are distributed to providers to ensure regulatory and contract compliance

3. What do the Any Willing Provider (AWP) and Any Willing Plan (AWP) provisions mean for residential providers?

- The NJ FamilyCare MLTSS MCO contract has a two-year *Any Willing Provider* and *Any Willing Plan* (AWP) provisions for providers in these categories: Assisted Living (AL), Community Residential Services (CRS), Nursing Facility (NF) and Special Care Nursing Facilities (SCNF).
- The AWP provisions include any New Jersey-based NF, SCNF, AL or CRS provider. It also includes any long-term care pharmacy that applies to become a network provider. The pharmacy must comply with the pharmacy benefit plan (PBM) provider network requirements; and accept the terms and conditions of the health plan provider contract, or terms for network participation.
- If the health plan wishes to have any New Jersey-based NF, SCNF, AL or CRS join its network, the providers will be instructed to complete an application form and conform with the MCO contract provisions.

4. What steps does a non-residential provider need to complete to be a provider with an MCO that administers the MLTSS benefit?

- a) Inquire if the MCO is accepting applications for service;
- b) Submit an application;
- c) Complete the credentialing requirements, and,
- d) Secure a contract if the MCO and provider reach a contract agreement.

5. What are the MCO contact numbers for provider relations and MLTSS?

- The following are the special Provider Relations department numbers at each MCO:

NJ FAMILYCARE Health Plan	Provider Relations	MLTSS Contacts
Aetna Better Health of New Jersey	1-855-232-3596	1-855-232-3596
Amerigroup New Jersey, Inc.	1-800-454-3730	1-855-661-1996
Horizon NJ Health	1-800-682-9091	1-877-765-4325
UnitedHealthcare Community Plan	1-888-362-3368	1-888-702-2168
WellCare of New Jersey	1-888-453-2534	1-888-453-2534 or 588-9769

The member and provider service contact information for each NJ FAMILYCARE MCO is also available on the DHS web-site at <http://www.state.nj.us/humanservices/dmahs/info/resources/hmo/>

MCO CONTRACT PARAMETERS ON BENEFITS COORDINATION WITH OTHER INSURERS

1. What is a “bypass” letter?

- For calendar year 2014, the Medicaid Fraud Division (MFD), Division of Medical Assistance and Health Services (DMAHS), with Molina Medicaid Solutions prepared a letter known as a bypass letter. It was done for individuals receiving Medicaid Waiver services on one of these NJ FamilyCare programs: Global Options for Long-Term Care (GO); AIDS Community Care Alternatives Program (ACCAP); Community Resources for People with Disabilities (CRPD), or the Traumatic Brain Injury (TBI) Waiver. As background, the MFD Third Party Liability (TPL) Unit had to confirm the individual member’s insurance information by reviewing the explanation of benefits (EOB) from the individual insurers. The special letter then confirmed that although the member had insurance coverage, it either did not cover the type of service included in the waiver or benefits were exhausted. The end date of the bypass letter was June 30, 2014.

2. What is the importance of the bypass letter with regard to MLTSS?

- The NJ FamilyCare managed care organizations (MCOs) must accept a bypass letter from their MLTSS members as a substitute for the denial of coverage of specified MLTSS services during the timeframe of July 1 to December 31, 2014. While the end date on the bypass letters may specify June 30, 2014, if the insurance carrier and service remain the same as was identified in the letter, the bypass letter is applicable for services delivered from July 1 to December 31, 2014.

3. Does an MLTSS provider serving a member with a Medicare Fee-for-Service and/or a Medicare Supplemental Plan need EOB information or a claim denial before the NJ FamilyCare MCO can pay?

- Providers serving MLTSS members who have a Medicare Fee-for-Service (FFS) and/or a Medicare Supplemental plan and are in an Assisted Living Programs (ALP), including Assisted Living Residential (ALRs/ALPs), Medical Day Care (MDC), social day care and Personal Care Assistance (PCA) do not have to obtain an EOB or claim denial from Medicare prior to submitting a claim to the NJ FamilyCare MCO.
- However, if a service is covered by Medicare, the provider must submit an EOB denying service from Medicare to be considered for payment from the NJ FamilyCare MCOs.

4. Does an MLTSS member in the Personal Preference Program, without Medicare Advantage coverage or commercial insurance, need an EOB or a claim denial before the NJ FamilyCare MCO can pay for PCA services?

- An EOB statement does not apply to the PPP cash grant “service” because the state’s Fiscal Intermediary (FI), Community Access Unlimited (CAU), is billing for funds that are part of the monthly spending plan approved for an MLTSS member.
- An EOB is not required if the member does not have Medicare Advantage or commercial insurance because PCA is for help with Instrumental Activities of Daily Living (IADLs) and Activities of Daily Living (ADLs) and is neither considered a medical service nor a service covered by any other medical payer.

5. **If a member has Medicare Advantage coverage that includes benefits covered under Medicare Parts A and B, and possibly Medicare Part D and/or another commercial coverage, does a NJ FamilyCare provider have to submit an explanation of benefits or denial of claim before the NJ FamilyCare MCO will process the claim?**
- Yes, the NJ FamilyCare MCO should require an EOB annually for an MLTSS member with a Medicare Advantage Plan and/or another commercial insurance. When an EOB is received indicating that the service is not covered by the primary insurer, the MCO will pay for MLTSS as the primary payer. A new EOB should not be required for subsequent claims during the calendar year for the same payer, provider, MLTSS member and service code.
 - Services paid by a TPL carrier may become a non-paid service if the MLTSS member's benefits are exhausted. If this is the case, the provider should submit an EOB stating the benefit is exhausted before the MCO pays for the service.

MCO CONTRACT PARAMETERS FOR MLTSS PROVIDERS

1. **What federal/state regulations govern the payment of claims and the issuance of prior authorizations under the NJ FamilyCare (NJ FAMILYCARE) managed care contract?**
- Existing law was amended and supplemented by L. 2005, c. 352 (Chapter 352) – the Health Claims Authorization, Processing and Payment Act (HCAPPA). As of July 11, 2006, health plans must have processes and procedures for providers regarding the handling of claims; claims payment appeals; prior authorization processes; utilization management; appeal rights and obligations; and information about clinical guidelines and claim submissions.
2. **What are the prior authorization parameters in the Health Claims Authorization Processing and Payment Act (HCAPPA)?**
- As mandated in the HCAPPA, prior authorization decisions for non-emergency services need to be made within 14 calendar days. Prior authorization denials and limitations must also be provided in writing.
3. **What is the timeframe for MLTSS claims' submission?**
- In compliance with HCAPPA Managed Care, claims are considered timely if they are submitted within 180 days of the date of service.
4. **What claims submission requirements must MCOs follow to meet NJ FamilyCare Contract parameters?**
- The MCOs must capture and adjudicate all the claims submitted by providers and comply with NJ FamilyCare's data reporting requirements. The MCOs must ensure the coordination of benefits by exhausting all other payment sources before NJ FamilyCare pays. The provider must follow the process established by each plan to submit claims.

5. What is the universal billing format for MLTSS?

For paper submissions:

- Providers need to use the “1500” form for AL facilities, HCBS service providers, and non-traditional providers such as home improvement contractors, emergency response system providers, meal delivery providers and more.
- Providers need to use the “UB-04” form for NFs and SCNFs.

For electronic submissions:

- Providers need to use the “837 P” form for AL facilities, HCBS service providers, and non-traditional providers such as home improvement contractors, emergency response system providers, meal delivery providers and more.
- Providers need to use the “837 I” form for NFs and SCNFs.

6. What are the claims submission requirements of providers if there is an explanation of benefits?

- The MCO contract specifies consistent claim submission timelines across all plans. Timeframes are consistent with the New Jersey Division of Banking and Insurance (DOBI) for all medical services.
- Providers are to submit coordination of benefits (COB) claims within 60 days from the date of the primary insurer’s explanation of benefits (EOB) or 180 days from the dates of service, whichever is later.

7. What are the claims processing requirements of the MCOs?

- The MCO contract language specifies that MLTSS service claims should be processed by the MCO to the provider within 15 days of a clean submission. For non-MLTSS services, the MCO contract language specifies that claims should be processed by the MCO to the provider within 30 days of a clean submission.

8. What are the claims submission categories?

- The claim submission categories are as follows:
 - a) Initial
 - b) Claim resubmission
 - c) Claim denial
 - d) Claims appeal

9. What is a claim re-submission?

- A claim may get denied for a variety of reasons, so it is important for a provider to supply the MCO with as much information as possible when re-submitting a claim. Some common reasons for a claim re-submission include: a corrected claim, the addition of prior notification/prior authorization information, and the verification of a bundled claim.

10. How does the coordination of benefits work for MLTSS members?

- If a member has another health or casualty insurer, the MCO is responsible for coordinating benefits to maximize the utilization of third party coverage and ensure that NJ FamilyCare is the payer of last resort. The provider must follow each MCO's process for submitting claims. (Refer to the section entitled **MCO Contract Parameters on Benefits Coordination with other Insurers.**)

11. What are the policies on “balance billing” with MLTSS for providers?

- A provider shall not seek payment from, and shall not institute or cause the initiation of collection proceedings or litigation against, a beneficiary, a beneficiary's family member, any legal representative of the beneficiary, or anyone else acting on the beneficiary's behalf unless the service does not meet criteria referenced in NJAC 10:74-8.7(a).
- For more information on the issue of balance billing and the limitations regarding the billing of NJ FamilyCare beneficiaries, refer to the Division of Medical Assistance and Health Services' *Medicaid/NJ FamilyCare Newsletter*: Volume 23 No. 15 dated September 2013. All NJ FamilyCare newsletters are posted on <http://www.njmmis.com/>

12. What are the Utilization Management Appeal parameters in the HCAPPA?

- An appeal or “adverse benefit decision” is included as part of the MCO contract for any member and/or provider who is not satisfied with the MCO's policies, procedures, a decision made by the MCO, or disagrees with the MCO as to whether a service, supply, or procedure is a covered benefit, is medically necessary, or is performed in the appropriate setting.

13. What is the MCO function with regard to complaints, grievances and appeals?

- An MLTSS member has three stages to appeal an adverse benefit determination by an MCO for medical services in addition to the option of asking for a Medicaid Fair Hearing.
- For non-medical services, the MLTSS member has two stages of appeal plus the option to ask for a Medicaid Fair Hearing.
- A member can file a complaint or grievance or a representative, such as a family member or a provider, can file on the member's behalf with the member's written consent.

14. Will the member continue to receive MLTSS during his/her appeal process or the Medicaid Fair Hearing process?

- During all stages of the appeal process or the Medicaid Fair Hearing process, services will continue while the appeal is being reviewed. However, the following conditions must apply:
 1. The appeal is filed on time;
 2. The appeal involves a previously authorized course of treatment;
 3. The services were ordered by an authorized provider, and,
 4. For those who requested a Medicaid Fair Hearing, continuation of benefits must be requested in writing within 20 days of the date of the denial letter.

15. What is the process to request a Medicaid Fair Hearing?

- A beneficiary or a provider on the beneficiary's behalf (with his/her written consent) can request a Medicaid Fair Hearing at any time during the appeal process.
- The Medicaid Fair Hearing Unit is available at 609-588-2655. The adverse decision letter must be mailed to the address below:

Division of Medical Assistance and Health Services
Fair Hearing Section
P.O. Box 712
Trenton, NJ 08625-0712

MLTSS CONTRACT PARAMETERS FOR RESIDENTIAL PROVIDERS

1. What are the covered services included in the per diem rates for NFs, SCNFs and AL facilities?

- The State has agreed that the default rate for NF, SCNF, AL and CRS facilities during the AWP period ending June 30, 2016 will be the higher of: (a) the rate set by the state as of April, 2014 with the possibility of an increase each fiscal year for inflation, dependent upon available appropriation; and, (b) the negotiated rate between the contractor and the facility. This does not preclude volume based rate negotiations and agreement between the contractor and these providers. If a negotiated rate cannot be agreed upon, the rate will default to the state rate. A statement will be added to the verbatim language for provider agreements section in the MCO contract for AWP providers.
- The DHS can also confirm that the MCO contract language regarding AL programs is inclusive of all AL programs including comprehensive personal care and AL programs; therefore, we do not believe additional contract language is necessary.

2. Are there exclusions for specialty items, such as special beds and wound vacuums, in the provider contracts with the MCOs?

- The state confirms that the established managed care rates for long term care facilities and assisted living providers are the fee-for-service per diem rates currently in effect, and includes those additional contracted services that will be provided under MLTSS for the AWP period ending June 30, 2016. There is nothing in the MCO contract that would preclude some or all providers and the MCOs to mutually agree to enter into global payment arrangements before the AWP period concludes.

3. How will "bed hold" days be handled under MLTSS?

- The reporting requirements for bed hold are outlined in individual MCO contracts with the residential providers. In the MLTSS Service Dictionary and on the UB-04 and 8:371, bed hold days do not have a reimbursement value, but they will be reported in a claim.

4. Does the provider bill for "bed hold" on the UB-04 when a resident is hospitalized or does the resident need to be discharged when going to a hospital under MLTSS?

- Bed hold information will be reported in the parameters of the MCO contract with providers; in the MLTSS Service Dictionary and on the UB-04 line 8:371. Bed hold days do not have a reimbursement value but they will be reported on a claim.
5. **How will remittance advices for long term care be handled under MLTSS?**
 - The long-term care facilities will need to follow each MCO's guidelines.
 6. **How will the number of monthly Medicaid days be reported post MLTSS implementation? Will it differ for residents on MLTSS versus those residents on fee-for-service Medicaid?**
 - The long-term care facilities will need to continue to report their census through the NJ Medicaid Management Information System (NJMMIS.)
 7. **Will pharmacy services remain the same for the NFs and SCNFs?**
 - Pharmacy service procedures will depend on the contracts which the NJ FamilyCare MCOs have with each long-term care facility.
 8. **How will the provider bill for room and board in the long-term care facilities under MLTSS?**
 - Room and Board will continue to be collected by the long-term care facilities. The MCO payment to facilities will be outlined in the MCO contract with providers.
 9. ***How are therapeutic leave days handled under MLTSS?**
 - Therapeutic leave days will not be paid, but they will be reported.

MLTSS MEMBER ELIGIBILITY CONFIRMATION

1. **Why must a provider confirm a member's eligibility status in NJ FamilyCare and/or the individual's enrollment in a NJ FamilyCare MCO for MLTSS?**
 - Providers must have the information on an individual's NJ FamilyCare status to be sure that the prior authorization is obtained from the correct entity so that the billing is submitted to the correct payer. If a provider has inaccurate information and, as a result, bills incorrectly, the provider may not be able to file in a timely manner and will lose reimbursement.
2. **What is a provider's requirement in terms of confirming a member's eligibility in NJFamilyCare?**
 - Providers must confirm a member's NJ FamilyCare eligibility on a monthly basis to ensure that the member remains enrolled in the program. If a member has changed MCOs, providers must contact the existing health plan for an updated authorization. Providers also must confirm that the member is enrolled in an MCO with an active authorization to receive MLTSS.

3. How can a provider check a member's eligibility status in NJ FamilyCare and/or the member's enrollment in a NJ FamilyCare MCO for MLTSS?

- There are two methods available for providers to verify a beneficiary's eligibility status:
 - a) The first option is to access REVS or the Recipient Eligibility Verification System if the provider is a NJ FamilyCare fee-for-service (FFS) provider. The provider may call 1-800-676-6562 to verify an individual's NJ FamilyCare eligibility and, at the same time, confirm if the individual has Medicare Parts A and B coverage. REVS may also be used to access health plan membership information.
 - b) The State has a second option to verify eligibility using the internet, which is referred to as eMEVS or the Electronic Medicaid Eligibility Verification System. This System is supported on a secure area of the www.njmmis.com website. A provider may visit www.njmmis.com and select the link on the left side of the page called "Contact Webmaster." The provider will complete a screen to request a username and password in order to access eMEVS. When using eMEVS, a provider has the option of entering a card control number from the health benefits identification (HBID) card; the beneficiary's social security number or name. EMEVS displays a formatted eligibility response on the computer, which a provider can view quickly and print for their records.
- Any provider with an active login ID and password may access the web portal. However, a provider may only verify a member's NJ FamilyCare eligibility for service dates that fall within that provider's NJ FamilyCare provider eligibility period. For example, if a provider is eligible to participate in NJ FamilyCare as a valid provider between 01/01/13 and 12/31/13 and the service date for a member is 01/01/14; the provider would not have access to that member's eligibility information since the service date to be verified is outside of that provider's NJ FamilyCare provider eligibility period.

MLTSS MEMBER ENROLLMENT AND ELIGIBILITY INFORMATION

1. Can an Assisted Living (AL) resident who already is enrolled in one NJ FamilyCare MCO change to a different MCO due to the transition of AL services to MLTSS? Is this a good cause situation? What happens if, for some reason, the AL is not part of the network of the MCO the resident is enrolled in?

- All NJ FamilyCare MCO beneficiaries can change their MCO to another MCO during the open enrollment period, which runs annually from October 1 – November 15.
- In addition, if a member has good cause, he/she can call NJ FamilyCare at 1-866-472-5338 (TTY 800-701-0720) at any time to ask about changing his/her MCO to another MCO.
- The NJ FamilyCare MLTSS MCO contract has two-year *Any Willing Provider* and *Any Willing Plan* (AWP) provisions for Assisted Living (AL), Community Residential Services (CRS), Nursing Facility (NF) and Special Care Nursing Facilities (SCNF) providers.

2. Who is doing the semi-annual recertification?

- Level of care determinations will be conducted annually by the MCO for MLTSS participants.

3. Is there a waiting period for MLTSS services?

- Yes, an individual must be enrolled in an MCO and determined to be clinically and financially eligible to receive MLTSS services. The enrollment into an MCO may take up to 60 days.

NF and AL services may be paid on a fee-for-service (FFS) basis when enrollment in the MCO is pending.

4. Are there still a Medicaid Track 1 and Track 2 in NFs and what is the impact on enrollment in MLTSS?

Members approved and enrolled in an MCO for MLTSS will not have Track 1 and Track 2 designation, since an MLTSS individual has met NF LOC and financial eligibility for an institutional setting. However, the Track 1 and Track 2 designation will be used for individuals who have not been enrolled in MLTSS.

5. Will a SCNF be able to request an exemption from enrollment in MLTSS for an individual on NJ FamilyCare who is in a brain injury special unit?

- Medicaid eligible individuals who are admitted to a SCNF prior to July 1, 2014 are exempt from MLTSS for a period of up to two years. Medicaid individuals admitted to a SCNF after July 1, 2014 will be enrolled into MLTSS.

6. If a NJ FamilyCare member needs to stay in a SCNF beyond the 30th day, will the MCO automatically disenroll the patient?

- The 30-day limit goes away for new residents on NJ FamilyCare admitted after July 1, 2014, or for those who switch from another payer to NJ FamilyCare after July 1.

7. An individual is admitted to a trauma center and his/her application for NJ FamilyCare is submitted while in acute hospital. The patient is then transferred to another hospital for acute rehabilitation. The individual is found eligible for NJ FamilyCare. Will the NJ FamilyCare MCO be assigned while the patient is still in the acute care hospital?

- While the individual is in an acute care hospital, the individual will remain FFS until they are discharged from the acute care hospital. Enrollment in an MCO will take place when the member is discharged from the acute care hospital.

8. An individual is admitted to a trauma center and started his/her application for NJ FamilyCare while hospitalized. The patient is then transferred to a long-term care facility for rehabilitation. NJ FamilyCare is later approved and a NJ FamilyCare number is assigned. Will the NJ FamilyCare MCO be assigned while the patient is still in the long-term care facility?

- Yes, the member will be enrolled in a NJ FamilyCare MCO when the member is discharged from the hospital.

9. An individual is admitted to a sub-acute rehabilitation facility for a traumatic brain injury. The individual's application for NJ FamilyCare is pending and not yet approved. What entity provides the pre-authorization for admission to a SCNF if there is no NJ FamilyCare MCO yet involved?

- The Division of Aging Services (DoAS)/Office of Community Choice Options (OCCO) is responsible for determining if an individual meets the clinical requirements for NJ FamilyCare MLTSS by using the NJ Choice assessment tool when the member's Medicaid eligibility is pending.
- 10. An individual already is on NJ FamilyCare before a traumatic event. The individual is admitted to a sub-acute rehabilitation facility. Before the transition to MLTSS, this individual would have been disenrolled from NJ FamilyCare on day 31. Has this policy changed with the transition to MLTSS on July 1, 2014?**
- The 30-day limitation on NJ FamilyCare coverage ended after July 1, 2014 with the move to MLTSS. As a result the NJ FamilyCare member's long term care is managed by the member's MCO.

PATIENT PAY LIABILITY/COST SHARE

1. Who will calculate cost share/patient pay liability (PPL) for individuals applying for Institutional Medicaid?

- The County Welfare Agency (CWA), on behalf of the State of New Jersey, will calculate the cost share for individuals determined eligible for MLTSS.

2. How does the CWA determine a Medicaid recipient's cost share?

- Cost share is calculated using the post-eligibility treatment of income rules outlined by the federal government at 42 CFR 435.725 and 435.726. The rules specify the deductions that are allowed to be paid out of a Medicaid recipient's income before their cost share or PPL is determined.
- The CWA office staff will complete a Patient Responsibility (PR) form for individuals eligible for MLTSS services.
 - a) PR1, (formerly PA3L) for nursing facility (NF) residents,
 - b) PR 2 for Assisted Living residents and
 - c) PR3 for individuals living in the community.

Sample Cost Share Calculation for NF Resident

John meets institutional level of care and needs to live in a NF. He establishes a Qualified Income Trust (QIT) in the month before he attains NJ FamilyCare eligibility. John's income of \$2,100 is \$1,500 a month in Social Security and \$600 per month in pension. John is married to Mary, she has an income of \$800 per month in Social Security and has shelter costs of \$700 a month plus she pays utilities.

Mary's Community Spouse Maintenance Allowance is calculated as \$1966.25 minus her income of \$800 which equals \$1,166.25. Mary's excess shelter cost allowance is calculated as \$700 minus the shelter allowance of \$589.88 which equals \$110.12. Mary also pays for her utilities which will increase her allowance by a flat \$491 per month. Mary's Community Spouse Maintenance Allowance will total \$1,767.37 per month.

John's total income = \$2,100

To calculate John's cost share, the PR-1 form allows for the following deductions:

\$2,100.00

- 35.00 Personal Needs Allowance

- 1,767.37 Community Spouse Maintenance Allowance

- 100.00 Health Insurance Premium

\$ 197.63 Available for cost share to be collected by the NF

Sample Cost Share Calculation for Assisted Living Facility

William meets an institutional level of care and would like to be in Assisted Living. William's income of \$2,000 includes \$800 in Social Security and \$1,200 in pension. William is married to Lauren. She has an income of \$1,500 which includes \$900 in Social Security and \$600 in pension. Her shelter costs are \$850 per month and she does not pay utilities.

Lauren's Community Spouse Maintenance Allowance is calculated as \$1,966.25 minus her income of \$1,500 which equals \$466.25. Her excess shelter costs are calculated as \$850 minus \$589.88 which equals \$260.12 and there is not a utility allowance added. Lauren receives \$726.37 from William as her total Community Spouse Maintenance Allowance.

William's total income = \$2,000

To calculate William's cost share, the PR-2 form allows for the following deductions:

\$2,000.00	Total Income
- 883.05	Maintenance Needs Allowance (R & B \$774.05 + PNA -\$109)
- 726.37	Community Spouse Maintenance Allowance
- 100.00	Health Insurance
- _____	<u>No unreimbursed medical expenses</u>
\$ 290.58	Available for cost share to be collected by the AL facility

3. How will the cost share/patient pay liability be communicated to AL and NF providers?

- The CWA will enter the cost share amount in the New Jersey Medicaid Management Information System (NJMMIS). and send notification to the NF or AL provider. In addition, the notification will be sent to the member and/or the member's designee.

4. Who will collect the cost share from member?

The Medicaid recipient or their representative will pay the cost share directly to the NF or the AL, for Home Base services, it will be paid directly to DMAHS.

5. Should the Provider begin collecting contribution from member when they are pending Medicaid eligibility?

- Based on Post Eligibility Treatment of Income Regulations 42 CFR 435.725 and 435.726 the provider should educate members and/or representatives regarding patient responsibilities.
- When the PR 1 and PR2 is approved by CWA and entered in NJMMIS the amount will be deducted from MCO payments and FFS payments.

6. How is the patient payment liability going to be accounted for by the MCO?

- Cost share/patient payment liability (PPL) will be deducted from the NF and/or AL provider payments. The MCO's process to account for cost share and payment to facilities will be outlined in the individual MCO contract with providers.

7. How are the members cost share communicated to MCO?

- The DHS sends a weekly file to the MCO with the PPL identified. The capitation payment from the State for the individual members to the MCO will be reduced by the State based on the individual member's cost share/PPL.
- The MCO will communicate with the provider as to the amount of PPL and the process which the MCO will use for billing.

8. How will retroactive cost share/patient pay liability be communicated to MCO?

- The weekly PPL History File from the state for the individual members to the MCO will be adjusted based on the retroactive cost share/patient pay liability. The MCO will work directly with the provider to account for the retroactive cost share.

NURSING FACILITY RESIDENT DISCHARGE

1. A nursing facility resident (NF) resident, who is Medicaid fee-for-service (FFS) was living in the NF before July 1, 2014, but is now transitioning into the community or another NF. How does the resident become enrolled in a NJ FamilyCare MCO to obtain MLTSS to either move into the community or another NF?

The Office of Community Choice Options (OCCO), Division of Aging Services (DoAS), Department of Human Services (DHS) continues to be responsible for the transition process of NF residents, who are FFS Medicaid, and are moving into the community or another NF. As part of the process, OCCO will conduct a new assessment on the NF resident with the NJ Choice assessment tool to determine the nursing home level of care. At this point, the NF resident will also receive Options Counseling to learn about his/her long term care options—MLTSS or the PACE program, and how to select a NJ FamilyCare MCO if MLTSS is chosen. OCCO then assists the resident in contacting NJ FamilyCare to choose the MCO and help the resident and/or family/responsible party with actually enrolling in a MCO. OCCO works directly with the NJ FamilyCare enrollment unit, which inputs the resident's MCO selection into the system.

1. How is a service plan developed for NF resident's transition into a home and community-based setting if the individual does not have an MCO? Does OCCO take the lead on this process since the person is Medicaid FFS?

For FFS Medicaid NF residents, OCCO serves as the lead entity in the process. An OCCO Community Choice Counselor is responsible for identifying potential residents who are able to move in the community, assessing care needs and help in choosing a community setting, etc. Once initial planning has taken place and specific

benchmarks are met, the member would need to be enrolled into an MCO during the next enrollment period. At this point, it is the MCO who then becomes responsible for the individual, participates in the discharge planning and develops his/her plan of care. The MCO's care manager participates in the Interdisciplinary Team (IDT) meeting to finalize the plan of care and discharge to the community setting. Once the NF transition IDT is convened, the MCO care manager assumes the lead for developing a plan of care and the transition/discharge planning. OCCO still continues to serve as the subject matter expert.

3. A FFS Medicaid NF resident wishes to sign himself out of the facility against medical advice. The individual is capable of making this decision from a cognitive standpoint. What is the process?

The Office of Community Choice Options (OCCO), Division of Aging Services (DoAS), Department of Human Services (DHS) continues to be responsible for the transition process of NF residents, who are FFS Medicaid, and are moving into the community or another NF. But in this situation, there is little (if any) lead time to coordinate MCO/MLTSS enrollment and schedule an IDT. If the resident wants to move into a home and community based setting with MLTSS and the resident is unwilling to remain in the NF until OCCO is able to facilitate the process, then the individual must handle the process in a different manner. The individual will need to contact the Aging and Disability Resource Connection/County Welfare Agency and apply for MLTSS from the community. The individual will still need to enroll into an MCO to enroll in MLTSS.

4. Does the LTC-2 form need to be generated and sent to OCCO when a NF resident in a NJ FamilyCare MCO has requested a transfer to another NF?

If the resident is already enrolled in an MCO, the MCO is always the primary point of contact for the provider. The MCO should be contacted regarding member's request to transfer. Upon admission to the new NF, the receiving facility would submit a LTC-2 form to OCCO. However, if the resident is FFS Medicaid, then the sending NF would have the resident/responsible party forward a letter to OCCO requesting a transfer to another NF: 1) OCCO would visit the resident in his/her current NF and complete the pre-admission screening process (PAS) that would trigger MLTSS enrollment; 2) OCCO would issue a transfer authorization letter; and, 3) upon admission, the receiving NF would submit a LTC-2 to OCCO so the provider number can be entered in the claims system to cover FFS until MCO/MLTSS enrollment occurs.

5. Who should the Residential Provider notify if they have a new Medicaid resident move into their facility?

The Provider should notify the CWA associated with the case. For example if a Ocean county member moves to a facility in Burlington County the facility should contact Ocean County CWA to insure continued eligibility for member. If CWA is not notified the member could lose benefits.

OPERATIONS

- 1. What is the MCO 's process authorization process for the NFs, ALs , CRS and SCNFs services?**
 - The MCO provider manual will outline the process for authorizing MLTSS services.
- 2. What is the MCO 's process authorization process for Home and Community Based services?**
 - The MCO provider manual will outline the process for authorizing MLTSS services.
- 3. Will clearinghouses be required for providers to use to submit claims to the NJ FamilyCare MCOs?**
 - The individual MCOs will outline the process for claim submissions.
- 4. Will the turn-around documents used by the NFs and SCNFs remain the same under MLTSS?**
 - The LTC-2, "Notification from Long Term Care Facility," form will continue to be submitted to OCCO. The form has been revised to reflect MLTSS.
- 5. How often do the long-term care facilities need to provide documentation under MLTSS to the MCOs?**
 - The answer depends on a variety of factors, including the individual resident's clinical needs and the MCO's care model. The MLTSS contract parameters between the MCOs and DHS outlines the standards to be followed for all MCOs.
- 6. Is supplementation in AL allowed?**
 - Supplementation is not allowed for Medicaid members.
- 7. Will pharmacy remain the same for AL?**
 - The prescriptions will be filled according to the NJ FamilyCare MCO program's formulary (list of medications) and policies. For specific information regarding prescription coverage, the resident will need to contact the Member Services department phone number on the back of his/her MCO Member ID card.
 - Medicare Part D benefits are not affected if the resident remains in traditional Medicare and a Medicare Part D Drug Plan, and is enrolled in a NJ FamilyCare MCO.
- 8. Please explain how the MCOs will coordinate behavioral health services for MLTSS residents of ALs, NFs, and SCNFs under MLTSS?**
 - The NJ FamilyCare MCOs will cover behavioral health services for MLTSS like they will handle other specialty care for their members in long-term care facilities who will need to visit specialists, i.e. podiatrists, pulmonologists and oncologists.

9. How often will the care managers from the MCOs meet with NF and SCNF residents enrolled in MLTSS?

- The timing of care management meetings with long-term care facility residents will depend on a variety of factors, including the individual resident's clinical needs, the MCO's care model and the MLTSS contract parameters between the MCOs and DHS.
- The contract stipulates a minimum of every 180 days for NF and Non-pediatric SCNF and every 90 days for Pediatric SCNF.

10. Does the NF have to have a contract with hospices that have a contract with the MCOs their residents are enrolled?

- The hospice provider must have an agreement/contract with the NJ FamilyCare MCO to offer hospice services.

11. How will claim adjustments be handled for NJ FamilyCare residents? Will claim adjustment forms be specific to each MCO? Will they be available online? Does the provider use claim adjustment forms to communicate the changes in resident income and leaves of absence?

- The individual MCOs will outline the process for claims submissions and adjustments.

12. Please explain the transition for AL residents. When will the contract between the MCO care managers and facilities begin?

- The AL residents transitioned to an MCO care manager on July 1, 2014. The timing of care management meetings with AL residents depends on a variety of factors, including the individual resident's clinical needs, the MCO's care model and the MLTSS contract parameters between the MCOs and DHS. The MCO care managers are responsible to continue all services and conduct telephonic outreach until a face-to-face visit and assessment are conducted no later than 180 days from July 1, 2014.

13. Providers are currently required to bill Medicare first to prove that Medicare is the primary payer for a dual eligible beneficiary? Does the process stay the same with MLTSS in that a provider must include a Medicare denial with the bill to the MCO?

If the beneficiary is dually eligible

- a. Medicare must be billed, prior to NJ FamilyCare, if the service is covered by Medicare:
- b. Medicare balances may be billed to the NJ FamilyCare MCO if the Medicare benefit is exhausted

The individual MCOs will outline the documentation required when a member is dually eligible.

RESOURCES FOR NJ FAMILYCARE MLTSS PROVIDERS

1. Are MLTSS resources available on the NJ Department of Human Services' website?

- Yes. The MCO contract is posted on line at <http://www.state.nj.us/humanservices/dmahs/info/resources/care/>
- The following link will connect you to the individual NJ FamilyCare MCO websites. Also included are phone numbers for the Member and Provider Relations units at the MCOs. It is <http://www.state.nj.us/humanservices/dmahs/info/resources/hmo/>.
- The following link includes MLTSS Information for Consumers and Stakeholders:

http://www.state.nj.us/humanservices/dmahs/home/mltss_resources.html

2. Who are the MLTSS contacts at DHS?

<i>DHS</i>	<i>MLTSS Contacts</i>
Division of Aging Service Provider Hotline	1- 866-854-1596
Division of Disability Services Care Management Hotline	1-888-285-3036
NJ FamilyCare Member/Provider Hotline	1-800-356-1561
NJ FamilyCare Health Benefits Coordinator (HBC)	1-800-701-0710
NJ FamilyCare Office of Managed Health Care, Managed Provider Relations	MAHS.Provider-inquiries@dhs.state.nj.us

TRANSITION FROM FEE FOR SERVICE APPROVAL TO MANAGED CARE

1. What is the process for providers to submit claims if the member is eligible for Medicaid and approved for Medicaid services but not enrolled in a MCO?

- Molina will process fee for service (FFS) claims and issue payment for members who are approved for Medicaid and approved for Fee for Service Medicaid services but not enrolled in an MCO. Refer to the NJMMIS website for instructions regarding claim submission.

2. If an individual is determined to be eligible for MLTSS what services are they eligible to receive?

- Members enrolled in MLTSS are eligible to receive state plan medical services included in the Plan A Benefit Package as well as services included in the MLTSS Service package.

http://www.state.nj.us/humanservices/dmahs/home/MLTSS_Service_Dictionary.pdf

3. **If an NJ FamilyCare member does not meet clinical eligibility for MLTSS are they eligible to receive home and community based services, if needed?**

Member enrolled in Medicaid Plan A as part of their State Plan benefit are eligible for Home Health Care-Non-Rehab, Home Health Care-Rehab, Personal Care Assistant and Medical Day Care- Adult.

Refer to <https://www.njmmis.com/downloadDocuments/23-20.pdf> for full description of State Plan services for NJ FamilyCare members.